Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Stephen Earle MD

Respondent Name
Liberty Insurance Corp

MFDR Tracking Number
M4-13-0284-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
September 25, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Each one of these codes was preauthorized by your office. As per the TDI-DWC Guidelines, once your code has been preauthorized it cannot be denied for medical necessity…. Each code is documented in the operative report Page 1 Paragraph 3 under surgical procedures performed in the body of the operative report.

Amount in Dispute: $12,965.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill and documentation attached to the medical dispute have been re-reviewed and our position remains unchanged. CPT Codes 22326 59, 22328, 63081, 63092 were denied as Pre-authorization was required, but no requested for this service per DWC Rule 134.600. Denied 63075/76 and 22554/22585 as X263. Texas uses CPT version 2012. "

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 25, 2012	22326, 22328, 22554, 22585, 63075, 63076, 63081, 63082	$12,965.00	$2,097.91

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

- X388 – Pre-authorization was requested but denied for this service per DWC rule 134.600
- X263 – The code billed does not meet the level/description of the procedure performed/documented
- X170 – Pre-authorization was required, but not requested for this service per DWC Rule 134.600
- X598 – Claim has been re-evaluated based on additional documentation submitted; no additional payment due

Issues

1. Did the requestor request and/or receive prior authorization of disputed services?
2. Was the authorized services supported by documentation?
3. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied disputed services 22326, 22328, 63081, and 63082 as X388 – "Pre-authorization was requested but denied for this service" and "Pre-authorization was required, but not requested for this service per DWC Rule 134.600. 28 Texas Administrative Code 134.600 states in pertinent part, "(p) Non-emergency health care requiring preauthorization includes: (1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay;" Review of the submitted documentation finds the following;

Date of Service	Submitted Code	Prior authorization requested	Prior authorization received	Denial Code
July 25, 2012	22326, 59	No	No	X388
July 25, 2012	22328	No	No	X388
July 25, 2012	63081	No	No	X170
July 25, 2012	63082	No	No	X170

Requirements of 28 Texas Administrative Code §134.600 not met, the Carrier's denial is supported.

2. The carrier denied disputed services 22554, 22585, 63075 and 63076 as X263 – "The code billed does not meet the level/description of the procedure performed/documented." 28 Texas Administrative Code §134.203(b)(1) states, in pertinent part, "for coding, billing reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; … and other payment policies in effect on the date a service is provided…" Review of the submitted documentation finds that the requestor performed surgical procedures. The American Medical Association (AMA) CPT code description for disputed services are:

   Procedure code 22554 – Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2.

   Procedure code 22585 – Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each addition interspace.

   Procedure code 63075 – Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophylectomy; cervical, single interspace.

   Procedure code 63076 – Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophylectomy; cervical, each additional interspace.

   Review of the submitted documentation finds:

   a. Prior authorization from Liberty Mutual dated June 12, 2012 for the following procedures
      i. Discetomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace.
   b. Document titled "Operative Report" states "Surgical Procedure(s) Performed: Anterior cervical decompression diskectomy, … C6-C7 additional interspace decompression. The division finds the authorized procedure, 63075, is supported by documentation. Reimbursement can be recommended.
   c. Per CCI Guidelines, Procedure Code 22554 has a CCI conflict with Procedure Code 63075, payment cannot be recommended.
   d. Per CCI Guidelines, Procedure Code 22585 has a CCI conflict with Procedure Code 63074, payment cannot be recommended.

e. Procedure code 63076, while document titled "Operative Report" shows additional procedure performed on C6-C7 (additional interspace), this procedure was not prior authorized as required by 28 Texas Administrative Code 134.600. No payment can be recommended.

3. 28 Texas Administrative Code §134.203(c)(1) states in pertinent part, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. The Maximum Allowable Reimbursement (MAR) is calculated as follows;

   (DWC Conversion Factor / Medicare Conversion Factor) x Non-Facility Price = TX Fee MAR or (54.86 x 34.0376) x $1,301.64 = $2,097.91. The total allowable is $2,097.91. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $2,097.91.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $2,097.91 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May , 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.